Complete Summary

GUIDELINE TITLE

Pelvic floor function and dysfunction. In: Guidelines on chronic pelvic pain.

BIBLIOGRAPHIC SOURCE(S)

Pelvic floor function and dysfunction. In: Fall M, Baranowski AP, Elneil S, Engeler D, Hughes J, Messelink EJ, Oberpenning F, Williams AC. Guidelines on chronic pelvic pain. Arnhem, The Netherlands: European Association of Urology (EAU); 2008 Mar. p. 74-6. [13 references]

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Chronic pelvic pain due to pelvic floor overactivity

GUIDELINE CATEGORY

Diagnosis
Evaluation
Management
Treatment

CLINICAL SPECIALTY

Colon and Rectal Surgery
Obstetrics and Gynecology
Urology

INTENDED USERS

Physicians

GUIDELINE OBJECTIVE(S)

- To help urologists in the clinical decisions they make every day
- To provide access to the best contemporaneous consensus view on the most appropriate management currently available

TARGET POPULATION

Patients with chronic pelvic pain arising from pelvic floor dysfunction

INTERVENTIONS AND PRACTICES CONSIDERED

Diagnosis/Evaluation

1. Classification of pelvic floor dysfunction: symptoms, signs, conditions
2. Locating myofascial trigger points

Management/Treatment

1. Biofeedback with pelvic floor muscle electromyography
2. Treatment of trigger points
    - Stretching the muscles
    - Muscle exercises
    - Pressure on trigger points and release
    - Injection trigger points with local anaesthetic

MAJOR OUTCOMES CONSIDERED

Rates of acute and chronic pain relief

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

A structured literature search was performed but this search was limited to randomized controlled trials and meta-analyses, covering at least the past three years, or up until the date of the latest text update if this exceeds the three-year

period. Other excellent sources to include were other high-level evidence, Cochrane review and available high-quality guidelines produced by other expert groups or organizations. If there were no high-level data available, the only option was to include lower-level data. The choice of literature was guided by the expertise and knowledge of the Guidelines Working Group.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Levels of Evidence

1a Evidence obtained from meta-analysis of randomized trials

1b Evidence obtained from at least one randomized trial

2a Evidence obtained from one well-designed controlled study without randomization

2b Evidence obtained from at least one other type of well-designed quasi-experimental study

3 Evidence obtained from well-designed non-experimental studies, such as comparative studies, correlation studies and case reports

4 Evidence obtained from expert committee reports or opinions or clinical experience of respected authorities

METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

- The first step in the European Association of Urology (EAU) guidelines procedure is to define the main topic.
- The second step is to establish a working group. The working groups comprise about 4 to 8 members, from several countries. Most of the working group members are academic urologists with a special interest in the topic. Specialists from other medical fields (pain medicine, psychology, radiotherapy, oncology, gynaecology, anaesthesiology, etc.) are included as full members of the working groups as needed. In general, general practitioners or patient representatives are not part of the working groups. Each member is appointed for a four-year period, renewable once. A chairman leads each group.
- The third step is to collect and evaluate the underlying evidence from the published literature.
- The fourth step is to structure and present the information. All main recommendations are summarized in boxes and the strength of the recommendation is clearly marked in three grades (A-C), depending on the evidence source upon which the recommendation is based. Every possible effort is made to make the linkage between the level of evidence and grade of recommendation as transparent as possible.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Grades of Recommendation

A. Based on clinical studies of good quality and consistency addressing the specific recommendations and including at least one randomized trial
B. Based on well-conducted clinical studies, but without randomized clinical studies
C. Made despite the absence of directly applicable clinical studies of good quality

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

The Appraisal of Guidelines for Research and Evaluation (AGREE) instrument was used to analyse and assess a range of specific attributes contributing to the validity of a specific clinical guideline. The AGREE instrument, to be used by two to four appraisers, was developed by the AGREE collaboration (www.agreecollaboration.org) using referenced sources for the evaluation of specific guidelines. (See the "Availability of Companion Documents" field for further methodology information).

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Dysfunction

Pelvic floor dysfunction should be classified according to 'The standardisation of terminology of pelvic floor muscle function and dysfunction'. This is an international multidisciplinary report from the International Continence Society (ICS). As in all ICS standardization documents, this is based on the triad of symptom, sign and condition. Symptoms are what the patient tells you; signs are found by physical examination. By palpation of the pelvic floor muscles, the contraction and relaxation are qualified. The voluntary contraction can be absent, weak, normal or strong. The voluntary relaxation can be absent, partly or completely. The involuntary contraction and relaxation is absent or present.

Based on these signs, pelvic floor muscles can be classified as follows:

- Non-contracting pelvic floor
- Non-relaxing pelvic floor
- Non-contracting, non-relaxing pelvic floor

Based on symptoms and signs, the following conditions are possible:

- Normal pelvic floor muscles
- Overactive pelvic floor muscles
- Underactive pelvic floor muscles
- Non-functioning pelvic floor muscles

Myofascial Trigger Points

Trigger points are defined as hyperirritable spots associated with a hypersensitive palpable nodule in a taut band. Trigger points are painful on compression and give rise to characteristic referred pain and motor dysfunction.

Pain as a result of these trigger points is aggravated by specific movements and alleviated by certain positions. Patients know what activities and postures influence the pain. Trigger points can be located within the pelvic floor muscle. In a case of pelvic floor muscle trigger points, a patient will sit down cautiously, often on one buttock. Rising after a period of sitting will cause pain. Pain will be aggravated by pressure on the trigger point (e.g., pain related to sexual intercourse). Pain will also get worse after sustained or repeated contractions (e.g., pain related to voiding or defecation). On physical examination, trigger points can be palpated and compression will give local and referred pain. In patients with chronic pelvic pain (CPP), trigger points are often found in muscles related to the pelvis like abdominal, gluteal and piriformis muscle.

Therapy

Treating pelvic floor overactivity should be considered in the management of CPP. There are a number of methods, taught by specialized physiotherapists, which can

be used to improve the function and co-ordination of the pelvic floor muscles. The use of biofeedback by means of pelvic floor muscle electromyography should be considered because it might help the patient to understand the dysfunction of the pelvic floor muscles. This understanding will improve the result of the treatment.

Central trigger points are treated by stretching the muscle, which inactivates them. However, trigger points lying in the attachment of the muscle to the bone respond better to direct manual therapy. Muscle exercises are helpful, e.g., voluntary contractions followed by complete relaxation. Pressure on the trigger points and subsequent release is also effective. Stretching of the muscle will be more effective after pain relief by direct pressure on the trigger point. Injecting the trigger points with a local anaesthetic will show that the trigger points are really causing the pain; it will give an acute relief of pain and will unblock the muscle so that stretching becomes possible.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is not specifically stated for each recommendation.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

- Accurate diagnosis and evaluation of pain due to pelvic floor dysfunction
- Appropriate management and treatment of pelvic floor dysfunction
- Improvement in function and co-ordination of the pelvic floor muscles

POTENTIAL HARMS

Not stated

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- The European Association of Urology (EAU) believes that producing validated best practice in the field of urology is a very powerful and efficient tool in improving patient care. It is, however, the expertise of the clinician which should determine the needs of their patients. Individual patients may require individualized approaches which take into account all circumstances and treatment decisions often have to be made on a case-by-case basis.

- There are some very clear limitations on the use of the EAU Guidelines. These guidelines are specifically aimed at helping the practising urologist and will thus be of limited use to other health care providers or third party payers. These are limitations which we have accepted, given that the aim is to cover all of Europe and that such non-clinical questions are best covered locally. Another limitation is that the texts have no medico-legal status, nor are they intended to be used as such.
- The purpose of this text is not to be proscriptive in the way a clinician should treat a patient but rather to provide access to the best contemporaneous consensus view on the most appropriate management currently available. EAU guidelines are not meant to be legal documents but are produced with the ultimate aim to help urologists with their day-to-day practice.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

The European Association of Urology (EAU) Guidelines long version (containing all 19 guidelines) is reprinted annually in one book. Each text is dated. This means that if the latest edition of the book is read, one will know that this is the most updated version available. The same text is also made available on a CD (with hyperlinks to PubMed for most references) and posted on the EAU websites Uroweb and Urosource (www.uroweb.org/professional-resources/guidelines/ & http://www.urosource.com/diseases/).

Condensed pocket versions, containing mainly flow-charts and summaries, are also printed annually. All of these publications are distributed free of charge to all (more than 10,000) members of the Association. Abridged versions of the guidelines are published in European Urology as original papers. Furthermore, many important websites list links to the relevant EAU guidelines sections on the association websites and all, or individual, guidelines have been translated to some 15 languages.

IMPLEMENTATION TOOLS

Pocket Guide/Reference Cards

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Living with Illness

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

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ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2008 Mar

GUIDELINE DEVELOPER(S)

European Association of Urology - Medical Specialty Society

SOURCE(S) OF FUNDING

European Association of Urology

GUIDELINE COMMITTEE

Not stated

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

All members of the Chronic Pelvic Pain guidelines writing panel have provided disclosure statements on all relationships that they have and that might be perceived as a potential source of conflict of interest. This information is kept on file in the European Association of Urology Central Office database. This guideline document was developed with the financial support of the European Association of Urology (EAU). No external sources of funding and support have been involved. The EAU is a non-profit organisation and funding is limited to administrative assistance, travel, and meeting expenses. No honoraria or other reimbursements have been provided.

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) from the European Association of Urology Web site.

Print copies: Available from the European Association of Urology, PO Box 30016, NL-6803, AA ARNHEM, The Netherlands.

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- EAU guidelines office template. Arnhem, The Netherlands: European Association of Urology (EAU); 2007. 4 p.
- The European Association of Urology (EAU) guidelines methodology: a critical evaluation. Arnhem, The Netherlands: European Association of Urology (EAU); 18 p.

The following is also available:

- Guidelines on chronic pelvic pain. 2005, Ultra short pocket guidelines. Arnhem, The Netherlands: European Association of Urology (EAU); 2008 Mar. 18 p.

Print copies: Available from the European Association of Urology, PO Box 30016, NL-6803, AA ARNHEM, The Netherlands.

PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI Institute on December 30, 2008. The information was verified by the guideline developer on February 27, 2009.

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